

FILED OCT 21 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 34963
8555

BIRTH NO. 61448450		REG. DIST. NO. 318	PRIMARY REG. DIST. NO. 1003	Registrar's No. 8555
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2119		
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 3905 West Belle Pl.		
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital				
3. NAME OF DECEASED (Type or Print) a. (First) Infant BABY JONES b. (Middle)		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) Sept. 28 1950
5. SEX Male 2	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Sept. 24, 1950	9. AGE (In years last birthday) 0 Months 0 Days 4 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME Grville Williams Jones	13b. MOTHER'S MAIDEN NAME Evelyn Williams	14. NAME OF HUSBAND OR WIFE --		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. --	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Evelyn Jones 3905 West Belle Pl.		
18. CAUSE OF DEATH Enter only one cause per line for (a); (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Spontaneous DUE TO (c) Gastric Rupture II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 7562		
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 6:15 P. M., from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) Samuel E. Taylor, Coroner		23b. ADDRESS 1300 Clark		23c. DATE SIGNED 10.10.50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Oct. 10, 1950	24c. NAME OF CEMETERY OR CREMATORY Washington Park Cem.	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. 067 10 1950	REGISTRAR'S SIGNATURE J. B. Pasater	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. H. Randle & Son 3133 Bell Ave.		

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

working under my personal supervision.

Student
Student Embalmer

Student Embalmer No.

Signed

Not Embalmed
J. H. Fuddle & Son

Licensed Embalmer No.

P. O. Address *3133 Bell*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.